

WISCONSIN STATE
LEGISLATURE
COMMITTEE HEARING
RECORDS

2005-06

(session year)

Assembly

(Assembly, Senate or Joint)

**Task Force on
Medical
Malpractice
(ATF-MM)**

Sample:

Record of Comm. Proceedings ... RCP

- 05hr_AC-Ed_RCP_pt01a
- 05hr_AC-Ed_RCP_pt01b
- 05hr_AC-Ed_RCP_pt02

➤ Appointments ... Appt

➤ **

➤ Clearinghouse Rules ... CRule

➤ **

➤ Committee Hearings ... CH

➤ **

➤ Committee Reports ... CR

➤ **

➤ Executive Sessions ... ES

➤ **

➤ Hearing Records ... HR

➤ **

➤ Miscellaneous ... Misc

➤ **05hr_ATF-MM_Misc_pt25**

➤ Record of Comm. Proceedings ... RCP

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WISCONSIN LEGISLATIVE AUDIT BUREAU AUDIT SUMMARY

Report 93-18

July 1993

PATIENTS COMPENSATION FUND

Physicians and other health care providers in Wisconsin are required by statute to purchase medical malpractice insurance from either private insurers or a public risk-sharing plan. The Patients Compensation Fund provides additional medical malpractice insurance in excess of primary coverage levels. The Fund is managed by a Board of Governors and administered by the Office of the Commissioner of Insurance.

Most health care providers in Wisconsin are required to participate in the Patients Compensation Fund, which is funded primarily through the fees they are assessed. In fiscal year (FY) 1991-92, fees totaled \$42.4 million and investment earnings were \$18.3 million. Fees are set annually by the Board based on providers' specialties. In FY 1992-93, they ranged from \$716 for nurse anesthetists to \$16,044 for physicians specializing in obstetric or neurological surgery.

Steps Should Be Taken to Reduce the Fund Deficit

One of the most significant concerns facing the Fund is an accounting deficit, which reflects the approximate amount that would not be available to pay estimated claims if the Fund were to cease operations and collect no additional fees. After declining from \$122.7 million at the end of FY 1987-88 to \$71.7 million as of June 30, 1991, the Fund's accounting deficit reversed direction and increased to \$79 million at the end of FY 1991-92. It is likely to continue increasing in the future.

Although the Fund's cash and investment balance was over \$197 million as of June 30, 1992, its ability to maintain large investment balances in the long term becomes uncertain as claim payments increase. The Fund paid almost \$44 million in claims and related expenses in FY 1991-92, and it is expected to pay almost \$49 million during FY 1992-93. Previously, the largest total paid in one year was \$26 million. Further, the Fund paid individual settlements of \$7.6 million, \$8.5 million, and \$18 million within the last two years, compared to a previous high of \$4.8 million in a single settlement.

We project the Fund could experience cash flow problems within the next 15 to 20 years if current claim trends continue and annual fees do not increase. Although potential cash flow problems appear to be a long-term concern, they will be difficult to address unless additional steps are taken to control the accounting deficit. Further, if national health care and medical malpractice reform efforts reduce or eliminate the need for the Fund, its ability to pay existing liabilities could become a more immediate concern.

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Annuity Purchases Present Potential Conflicts of Interest

When claim settlements require a series of payments over the claimant's lifetime, annuities are purchased on the Fund's behalf, either directly from an annuity company or with the services of an annuity broker. The Fund's claims contractor, who is responsible for purchasing annuities on behalf of the Fund, used its internal brokerage department to purchase \$12.6 million, or 83 percent, of claim settlement annuities totaling \$15.2 million during the audit period. Further, the last seven annuities purchased through the contractor's brokerage department, which totaled \$7.9 million, were purchased from the same annuity company.

The contractor's files indicate that its brokerage department obtained three quotations for the annuity purchases and that the selected annuity company offered the lowest price. However, there may be a perception that commissions the contractor receives from the annuity company, which range between 3 and 4 percent of the annuity price, provide an incentive for the contractor to act in its own, rather than the Fund's, best interest. Therefore, we recommend the claims contractor be prohibited from receiving commissions for annuities purchased for the Fund.

AN AUDIT OF
PATIENTS COMPENSATION FUND
OFFICE OF THE COMMISSIONER OF INSURANCE

JULY 1993

93-18

1993-94 Joint Legislative Audit Committee Members

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Peggy A. Rosenzweig, Co-chairperson
Joseph Leean
Robert Cowles
Brian Burke
Joseph Wineke

Assembly Members:

Kimberly M. Plache, Co-chairperson
Doris Hanson
Barbara Linton
Scott Jensen
Kathleen Krosnicki

LEGISLATIVE AUDIT BUREAU

The Bureau is a nonpartisan legislative service agency responsible for conducting financial and program evaluation audits of state agencies. The Bureau's purpose is to provide assurance to the Legislature that financial transactions and management decisions are made effectively, efficiently, and in compliance with state law, and that state agencies carry out the policies of the Legislature and the Governor. Audit Bureau reports typically contain reviews of financial transactions, analyses of agency performance or public policy issues, conclusions regarding the causes of problems found, and recommendations for improvement.

Reports are submitted to the Joint Legislative Audit Committee and made available to other committees of the Legislature and to the public. The Audit Committee may arrange public hearings on the issues identified in the report, and may introduce legislation in response to the audit recommendations. However, the findings, conclusions, and recommendations in the report are those of the Legislative Audit Bureau. For more information, contact the Bureau at 131 W. Wilson Street, Suite 402, Madison, WI 53703, (608) 266-2818.

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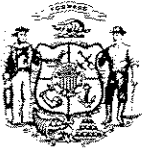
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State of Wisconsin \ LEGISLATIVE AUDIT BUREAU

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July 21, 1993

Senator Peggy A. Rosenzweig and
Representative Kimberly M. Plache, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, WI 53702

Dear Senator Rosenzweig and Representative Plache:

As required by s. 13.94, Wis. Stats., we have completed a financial audit of the Patients Compensation Fund, which provides medical malpractice insurance coverage in excess of statutory minimums to Wisconsin's health care providers. The Fund is governed by a Board and administered by the Office of the Commissioner of Insurance. We were able to provide an unqualified auditor's report on the Fund's financial statements for the fiscal years ending June 30, 1992, June 30, 1991, and June 30, 1990.

One of the most significant concerns facing the Fund is an accounting deficit, which reached \$79 million as of June 30, 1992. The Fund had a cash and investment balance of over \$197 million at the end of fiscal year 1991-92, which may take attention away from the accounting deficit. However, we project that if current trends continue, within the next 15 to 20 years the Fund could experience cash flow problems that may be difficult to address unless steps are taken soon to increase revenues or limit claim costs. Further, if national medical and malpractice reform efforts eliminate the need for the Fund, cash flow concerns would become more immediate. The Board has undertaken a study of alternatives for addressing the deficit.

In response to concerns raised in earlier audits, the Fund has taken several steps to improve its claim operations, although we note that the Fund needs to continue steps to improve the accuracy and timeliness of its claim information. Further, we believe there may be a potential conflict of interest when the claims contractor purchases claim settlement annuities through its internal brokerage department, which received an estimated \$378,000 to \$503,000 in commissions from annuity companies for the purchase of annuities for the Fund during our audit period.

We appreciate the courtesy and cooperation extended to us by the staff of the Office of the Commissioner of Insurance and the contractors who help administer the Patients Compensation Fund program. The response from the Commissioner of Insurance is the appendix.

Respectfully submitted,

Dale Cattanaach
State Auditor

DC/DA/ce

SUMMARY

The Patients Compensation Fund was created for the purpose of paying that portion of medical malpractice claims exceeding a specified amount as defined in Ch. 655, Wis. Stats. The Fund is managed by a Board of Governors, administered by the Office of the Commissioner of Insurance, and financed through assessments on most health care providers and through earnings on the Fund's investments.

By statute, the Audit Bureau is required to conduct financial audits of the Fund. This report covers fiscal years (FYs) 1991-92, 1990-91, and 1989-90. We issue an unqualified auditor's report on the financial statements' fairness of presentation, although we note that the amounts ultimately paid for claims may vary significantly from actuarially estimated amounts included in the financial statements because of the uncertainties inherent in making the estimates.

One of the most significant concerns facing the Fund is an accounting deficit, which reflects the approximate amount that would not be available to pay estimated claims if the Fund were to cease operations and collect no additional fees. Although the deficit declined to \$71.7 million at the end of FY 1990-91 after reaching a high of \$122.7 million in FY 1987-88, it again reversed direction and increased to \$79 million in FY 1991-92, and it is likely to continue increasing in the future unless additional steps are taken.

Some argue the Fund's financial picture is not as bleak as the accounting deficit would suggest because the Fund had a cash and investment balance of over \$197 million as of June 30, 1992. However, the Fund's continued ability to increase or even maintain investment balances in the long term becomes uncertain as annual amounts paid out in claims increase. The Fund paid almost \$44 million in claims and related expenses in FY 1991-92 and is expected to pay almost \$49 million during FY 1992-93. Previously, the largest amount of claims and related expenses paid in one year totaled \$26 million. Settlements of \$7.6 million, \$8.5 million, and \$18 million within the last two years, compared to a previous high of \$4.8 million, increase the likelihood of larger claim payments in the future.

Although it is difficult to predict the Fund's future cash flows because of the inability to predict future claim settlements, we project the Fund's cash and investment balance could begin declining within the next 10 years and the Fund could experience cash flow problems within the next 15 to 20 years, if current claim trends continue and the health care providers' annual fees remain at the FY 1993-94 fee level. Although potential cash flow problems appear to be a long-term concern, they will be difficult to address in the future unless additional steps are taken soon to control the accounting deficit. Further, it is unclear what effect national health care and medical malpractice reform efforts may have on the Fund. However, if the reform efforts

eliminate the need for the Fund, the ability to pay the Fund's existing liabilities could become a more immediate concern.

Therefore, it is important that the Board of Governors and the Legislature continue to monitor and assess the need for measures to address the deficit. The Board is establishing a study group, which will consist of members of the Board and fund staff, to evaluate different alternatives for addressing the deficit. The study group will be expected to report to the full Board by March 1994, at which time the Board will consider what steps to pursue. We recommend the Board of Governors report the results of its study committee and the Board's planned steps to address the deficit to the Joint Legislative Audit Committee by June 30, 1994.

The Fund's deficit emphasizes the need for the Fund to effectively and efficiently manage its claim operations. During our past audits, we identified deficiencies in the Fund's claim operations that resulted in significant errors in the accuracy of its claim information. Fund staff have shown a commitment to improve the Fund's operations and have taken several steps in recent years to address the deficiencies, although we note that the Fund needs to continue to improve the accuracy and timeliness of claim information.

Further, we have concerns with potential conflicts of interest when annuities are purchased through the claims contractor's internal brokerage department. The Fund's claims contractor, which is responsible for purchasing annuities on behalf of the Fund for claim settlements, used its internal brokerage department to purchase \$12.6 million, or 83 percent, of the total \$15.2 million in annuities purchased for the Fund during the audit period. The last seven annuities purchased through the contractor's brokerage department, which totaled \$7.9 million, were purchased from the same annuity company.

The contractor's files indicate that its brokerage department obtained three quotations for the annuity purchases, as required by the Fund's written procedures, and that the selected annuity company offered the lowest price. However, the perception may be that commissions the contractor receives from the annuity company, which range between 3 and 4 percent of the annuity purchase price, provide an incentive for the contractor to act in its own, rather than the Fund's, best interest. Further, the concentration of annuities in one annuity provider increases the risk to the Fund if the annuity provider were to become insolvent. A recent default on annuity payments totaling \$23,921 by one of the Fund's annuity providers, which the Fund subsequently paid, exemplifies the Fund's risk. Therefore, we recommend the Board of Governors prohibit the claims contractor from receiving commissions from annuity providers for annuities purchased for the Patients Compensation Fund and amend its annuity guidelines to include specific criteria for contracting with multiple annuity companies to further reduce the risk of defaults.

INTRODUCTION

Chapter 37, Laws of 1975, which was enacted in response to a crisis in the cost and availability of medical malpractice insurance, created the Patients Compensation Fund to provide medical malpractice insurance coverage in excess of statutory primary liability limits. Management of the Fund is vested in a 13-member Board of Governors, which is chaired by the Commissioner of Insurance. The Office of the Commissioner of Insurance provides staff for overall administration and contracts with private firms for claims handling and actuarial services.

By law, the Legislative Audit Bureau is responsible for performing a financial audit of the Patients Compensation Fund at least once every three years. As necessary parts of the financial audit, we reviewed the Fund's control procedures; assessed the fair presentation of its financial statements for the fiscal years (FYs) ending June 30, 1992, June 30, 1991, and June 30, 1990; and reviewed its compliance with statutory provisions. We also reviewed the status of the Fund's accounting deficit, which totaled \$79 million as of June 30, 1992, and evaluated progress in improving the Fund's claim operations, which had significant deficiencies in previous audits.

Wisconsin health care providers are currently required to maintain primary malpractice coverage of \$400,000 for each incident, up to a total of \$1 million for a policy year, with a private insurer or the Wisconsin Health Care Liability Insurance Plan, which is a public health care liability risk-sharing plan. Malpractice insurance in excess of the required minimum is available through the Fund, which has no limit on its liability for the claim.

Most health care providers permanently practicing or operating in Wisconsin are required to participate in the Fund and pay annual fees, which are assessed by the Board of Governors based on a provider's specialty. The statutes place a limit on the overall level of fees the Board of Governors can assess in any one year. For FY 1992-93, the annual fees for individual health care providers who practice primarily in Wisconsin ranged between \$716 for nurse anesthetists to \$16,044 for physicians specializing in obstetric or neurological surgery. In addition, hospitals and nursing homes pay on a per bed basis of \$176 and \$33, respectively, and partnerships and corporations providing medical services pay a fee, which ranges between \$100 and \$2,500, based on the number of health care providers in the organization. The number of health care providers participating in the Fund as of June 30, 1992 was 9,791, as shown in Table 1.

Table 1

**Health Care Providers Participating in the Fund
as of June 30, 1992**

<u>Provider Type</u>	<u>Number</u>
Physicians and Surgeons	7,216
Partnerships, Cooperatives, and Corporations	1,519
Medical College Staff	589
Nurse Anesthetists	310
Hospitals and Nursing Homes	<u>157</u>
Total	9,791

INDEPENDENT AUDITOR'S REPORT

We have audited the accompanying balance sheet—regulatory basis of the State of Wisconsin Patients Compensation Fund as of June 30, 1992, 1991, and 1990, and the related statement of income and changes in fund deficit—regulatory basis and statement of cash flows—regulatory basis for the years then ended. These financial statements are the responsibility of the Patients Compensation Fund's management. Our responsibility is to express an opinion on these financial statements, based on our audit.

We conducted our audit in accordance with generally accepted auditing standards and *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

As described in Note 1, the financial statements present only the Patients Compensation Fund and are not intended to present fairly the financial position of the State of Wisconsin, and the results of its operations and changes in financial position of its proprietary and trust fund types in conformity with generally accepted accounting principles.

As described in Note 2, the Patients Compensation Fund's policy is to prepare its financial statements in a format prescribed by the Board of Governors and in accordance with the accounting principles prescribed or permitted by the Commissioner of Insurance of the State of Wisconsin, which is a comprehensive basis of accounting other than generally accepted accounting principles.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Patients Compensation Fund as of June 30, 1992, 1991, and 1990, and the results of its operations and its cash flows for the years then ended, on the basis of accounting described in Note 2.

As discussed in Note 4 to the financial statements, the Patients Compensation Fund's projected ultimate loss liability is based on recommendations of a consulting actuary. The ultimate loss liability includes estimates for reported losses and estimates for incurred but not reported losses based on the projected ultimate losses. The management of the Patients Compensation Fund believes that the estimated loss liability is reasonable and adequate to cover the cost of claims incurred to date.

However, the ultimate losses incurred are difficult to estimate because of the nature of unlimited excess liability coverage provided and the limited historical experience of the Patients Compensation Fund. Because of the uncertainties, the amount that will ultimately be paid to settle these liabilities may vary significantly from the estimated amounts included in the accompanying balance sheet—regulatory basis.

Legislative Audit Bureau

June 4, 1993

by

Diann Allsen

Diann Allsen
Audit Director

Office of the Commissioner of Insurance
 Patients Compensation Fund
 Balance Sheet--Regulatory Basis
 June 30, 1992, June 30, 1991, and June 30, 1990

	June 30, 1992	June 30, 1991	June 30, 1990
Admitted Assets			
Cash and cash equivalents (Note 3)	\$ 44,153,307	\$ 43,684,567	\$ 143,685,621
Investment income receivable	2,650,264	1,315,033	3,009,249
Assessments receivable	587,850	303,198	139,623
Other receivables	10,489	14,775	36,738
Total receivables	3,248,603	1,633,006	3,185,610
Bonds (Note 3)	153,326,144	130,858,387	0
Office equipment	25,731	21,926	0
Total admitted assets	<u>\$ 200,753,785</u>	<u>\$ 176,197,886</u>	<u>\$ 146,871,231</u>
Liabilities and Fund Deficit			
Loss liabilities (Note 4)			
Incurred but not reported losses	\$ 304,598,834	\$ 272,137,413	\$ 242,685,033
Reported losses	43,447,530	51,501,951	39,182,445
Loss adjustment expense	14,941,950	11,454,114	8,455,803
Estimated unpaid loss liabilities	362,988,314	335,093,478	290,323,281
Amount representing interest	(92,783,058)	(88,589,682)	(74,564,361)
Discounted loss liabilities	270,205,256	246,503,796	215,758,920
Future medical expenses	304,351	289,462	316,433
Total loss liabilities	270,509,607	246,793,258	216,075,353
Other liabilities			
Assessments received in advance (Note 1)	8,549,354	832,926	4,316,264
Provider refunds	532,080	115,993	16,361
General and administrative expenses	57,768	74,250	54,395
Patients Compensation Panels	1,820	14,988	6,850
Vouchers Payable	85,837	46,059	0
Total liabilities	279,736,466	247,877,474	220,469,223
Fund deficit	(78,982,681)	(71,679,588)	(73,597,992)
Total liabilities and fund deficit	<u>\$ 200,753,785</u>	<u>\$ 176,197,886</u>	<u>\$ 146,871,231</u>

The accompanying notes are an integral part of this statement

Office of the Commissioner of Insurance
 Patients Compensation Fund
 Statement of Income and Changes in Fund Deficit--Regulatory Basis
 for the Years Ended June 30, 1992, 1991, and 1990

	For Year Ended June 30, 1992	For Year Ended June 30, 1991	For Year Ended June 30, 1990
Assessments written (Note 1)	\$ 42,350,118	\$ 43,936,723	\$ 43,161,220
Less underwriting expenses			
Net losses paid	41,733,144	24,383,758	23,945,574
Interest on loss payments	479,130	247,533	0
Loss adjustment expense paid	1,573,802	1,402,338	1,213,574
Medical expense paid	2,844	52,004	27,726
Change in liability for incurred but not reported losses	32,461,421	29,452,380	26,512,881
Change in liability for reported losses	(8,054,421)	12,319,506	5,108,606
Change in liability for loss adjustment expense	3,487,836	2,998,311	453,437
Change in amount representing interest	(4,193,376)	(14,025,321)	(36,266,516)
Change in liability for future medical expense	14,889	(26,971)	(1,143)
Total underwriting expenses	67,505,269	56,803,538	20,994,139
Net underwriting gain (loss)	(25,155,151)	(12,866,815)	22,167,081
Investment income	14,643,659	14,704,891	12,111,614
Gain on sale of bonds	3,640,266	0	0
Assessment interest income	696,745	820,621	763,050
Administrative fee income	49,985	58,261	32,969
Other income	8,706	13,949	4,260
Less general and administrative expense	(1,039,468)	(660,796)	(403,145)
	<u>\$ (7,155,258)</u>	<u>\$ 2,070,111</u>	<u>\$ 34,675,829</u>
Fund deficit, beginning of year	\$ (71,679,588)	\$ (73,597,992)	\$ (108,256,349)
Net income (loss)	(7,155,258)	2,070,111	34,675,829
Change in nonadmitted assets	(144,320)	(175,860)	(17,472)
Other adjustments	(3,515)	24,153	0
Fund deficit, end of year	<u>\$ (78,982,681)</u>	<u>\$ (71,679,588)</u>	<u>\$ (73,597,992)</u>

The accompanying notes are an integral part of this statement.

Office of the Commissioner of Insurance
 Patients Compensation Fund
 Statement of Cash Flows--Regulatory Basis
 for the Years Ended June 30, 1992, 1991, and 1990

	For Year Ended June 30, 1992	For Year Ended June 30, 1991	For Year Ended June 30, 1990
Cash Flows from Operating Activities			
Cash received from:			
Provider fund fees	\$ 51,536,378	\$ 41,905,283	\$ 46,319,493
Primary malpractice insurers	9,643,677	3,748,963	6,414,036
WHCLIP	34,294	37,446	34,317
Other operating activity	1,866	13,091	4,260
Cash payments for:			
Losses	(51,770,830)	(28,132,721)	(30,359,609)
Interest on loss payments	(479,130)	(247,533)	0
Loss adjustment expense	(1,644,831)	(1,379,211)	(1,213,574)
Medical expense	(2,844)	(52,004)	(27,726)
General and administrative expense	(974,645)	(627,841)	(443,179)
Provider refunds	(354,214)	(484,150)	(427,972)
Panel fees	0	(300,000)	0
Net cash provided by operating activities	<u>5,989,721</u>	<u>14,481,323</u>	<u>20,300,046</u>
Cash Flows from Capital and Related Financing Activities			
Aquisition of capital assets	<u>(8,760)</u>	<u>(23,952)</u>	<u>0</u>
Cash Flows from Investing Activities			
Purchase of investments	(86,707,538)	(126,588,626)	0
Proceeds from sales of investments	71,945,923		
Interest on investments	<u>9,249,394</u>	<u>12,130,201</u>	<u>11,812,686</u>
Net cash provided by investing activities	<u>(5,512,221)</u>	<u>(114,458,425)</u>	<u>11,812,686</u>
Net increase in cash and cash equivalents	468,740	(100,001,054)	32,112,732
Cash and cash equivalents, beginning of year	<u>43,684,567</u>	<u>143,685,621</u>	<u>111,572,889</u>
	<u>\$ 44,153,307</u>	<u>\$ 43,684,567</u>	<u>\$ 143,685,621</u>

The accompanying notes are an integral part of this statement.

Office of the Commissioner of Insurance
Patients Compensation Fund
Statement of Cash Flows--Regulatory Basis
for the Years Ended June 30, 1992, 1991, and 1990

	For Year Ended June 30, 1992	For Year Ended June 30, 1991	For Year Ended June 30, 1990
Reconciliation of Net Operating Income (Loss) to Net Cash and Cash Equivalents Provided by Operations			
Net income (loss)	\$ (7,155,258)	\$ 2,070,111	\$ 34,675,829
Less nonoperating income	(18,283,925)	(14,704,891)	(12,111,614)
Net operating income	(25,439,183)	(12,634,780)	22,564,215
Adjustments to Reconcile Net Operating Income (Loss) to Net Cash Provided by Operations			
Depreciation expense	9,646	5,106	0
Changes to assets and liabilities			
Decrease (increase) in assessments receivable	(284,652)	(163,575)	(81,710)
Decrease (increase) in other receivables	4,286	21,963	(30,927)
Decrease (increase) in nonadmitted assets	(159,368)	(155,642)	(17,472)
Increase (decrease) in loss liabilities	23,716,349	30,717,905	(4,192,735)
Increase (decrease) in other liabilities	8,142,643	(3,309,654)	2,058,675
Total adjustments	31,428,904	27,116,103	(2,264,169)
Net cash and cash equivalents provided by operating activities	\$ 5,989,721	\$ 14,481,323	\$ 20,300,046

The accompanying notes are an integral part of this statement.

NOTES TO FINANCIAL STATEMENTS

1. Description of the Fund

The Patients Compensation Fund, which is part of the State of Wisconsin financial reporting entity, was created in 1975 for the purpose of paying that portion of a medical malpractice claim that is in excess of the legal primary insurance limit prescribed in s. 655.23(4), Wis. Stats., or the maximum liability limit for which the health care provider is insured, whichever limit is greater. Most health care providers permanently practicing or operating in the State of Wisconsin are required to pay annual assessments.

Management of the Fund is vested with a 13-member Board of Governors, which is chaired by the Commissioner of Insurance. The Board has designated the Commissioner of Insurance as the administrator of the Fund. Similarly, under s. 655.27(2), Wis. Stats., the Commissioner shall either provide staff services necessary for the operation of the Fund or, with the approval of the Board of Governors, contract for all or part of these services. During FYs 1991-92, 1990-91, and 1989-90, the Board contracted for the Fund's actuarial and claim services.

2. Summary of Significant Accounting Policies

The significant accounting policies followed by the Patients Compensation Fund are summarized as follows:

Basis of Presentation

The accompanying financial statements have been prepared in a format prescribed by the Board of Governors in accordance with statutory accounting principles for property and liability companies, which are described in s. 655.27(4)(d), Wis. Stats., and s. Ins. 17.27(3), Wis. Adm. Code, and vary in some respects from generally accepted accounting principles. The most significant difference is that certain nonliquid assets, such as receivables outstanding for a period greater than 90 days, most office furniture and equipment, supplies inventory, and prepaid expenses, are designated as nonadmitted assets and are excluded from the balance sheet. Changes in the nonadmitted assets are applied to the fund deficit.

Investment Valuation

Bonds are valued at cost and adjusted for amortization of premiums and discounts using the effective interest method for zero-interest coupon

bonds and the straight-line method, which approximates the effective interest method, for other bonds. Realized gains and losses on sales of investments are recognized in net income on the specific identification basis. Investments in the State Investment Fund are considered cash equivalents and are carried at the cost of participating shares, which is also the realizable value as of June 30. Interest income, gains, and losses of the Investment Fund are allocated monthly.

Assessments

Assessments are billed and recognized on a fiscal year basis, which is also the policy year. The Fund records advance assessments received for the upcoming fiscal year as unearned assessments or deferred revenue. In FYs 1990-91 and 1989-90, assessments receivable were estimated based on prior experience. With the implementation of a new computer system, assessments receivable were based on actual provider accounts maintained by the computer system in FY 1991-92. Beginning in FY 1991-92, the new claim system also automatically credits the accounts of a provider whose primary insurance has lapsed.

Equipment

Although most office furniture and equipment are considered nonadmitted assets and excluded from the balance sheet, certain computer equipment may be capitalized under regulatory accounting principles. Beginning in FY 1990-91, the Fund began capitalizing allowable computer equipment with a purchase price greater than \$500. The computer equipment is depreciated under the straight-line method over the estimated useful life of the equipment.

3. Deposits and Investments

All cash is deposited with the State of Wisconsin Treasurer and is invested by the State of Wisconsin Investment Board through the State Investment Fund. Shares in the State Investment Fund are reported as cash equivalents. All of the Patients Compensation Fund's investments are managed by the State of Wisconsin Investment Board. The Investment Board's objectives are to invest moneys held in the Fund in investments with maturities and liquidity that are appropriate for the needs of the Fund.

Investments of the State Investment Fund consist of direct obligations of the United States government, securities guaranteed by banks, and other investments approved by the trustees of the State of Wisconsin Investment Board. Bonds purchased for the Patients Compensation Fund consist of U.S. Government obligations; corporate obligations; and public utilities and financial institution obligations.

All deposits and investments of the State Investment Fund and bonds required to be categorized by the Governmental Accounting Standards Board Statement Number 3 meet the criteria for risk category 1. Cash deposits in risk category 1 are insured or collateralized with securities held by the State or by its agent in the State's name. Investments and bonds in risk category 1 are insured or registered or are held by the State or its agent in the State's name. The Patients Compensation Fund's investments at year-end are shown as follows:

	<u>Bonds</u>	<u>Shares in State Investment Fund</u>
Carrying Value		
FY 1991-92	\$153,326,144	\$ 44,363,000
FY 1990-91	130,858,387	43,661,000
FY 1989-90	0	143,806,000
Market Value		
FY 1991-92	\$161,878,134	\$ 44,363,000
FY 1990-91	134,746,194	43,661,000
FY 1989-90	0	143,806,000

Major categories of investment earnings are summarized below:

	<u>FY 1991-92</u>	<u>FY 1990-91</u>	<u>FY 1989-90</u>
Bonds	\$11,827,591	\$ 9,130,132	\$ 0
State Investment Fund	2,670,507	5,541,547	12,111,614
Securities lending	145,561	33,212	0
Gain on sale of bonds	<u>3,640,266</u>	<u>0</u>	<u>0</u>
Total	<u>\$18,283,925</u>	<u>\$14,704,891</u>	<u>\$12,111,614</u>

4. Loss Liabilities

Loss liabilities include individual case estimates for reported losses and estimates for incurred but not reported losses based upon the projected ultimate losses. Individual case estimates of the liability for reported losses and net losses paid from inception of the Fund are deducted from the projected ultimate loss liabilities to determine the liability for incurred but not reported losses as follows:

	<u>June 30, 1992</u>	<u>June 30, 1991</u>	<u>June 30, 1990</u>
Projected ultimate loss liability	\$549,336,068	\$483,195,925	\$417,040,281
Less:			
Net loss paid from inception	(201,289,705)	(159,556,561)	(135,172,803)
Liability for reported losses	<u>(43,447,529)</u>	<u>(51,501,951)</u>	<u>(39,182,445)</u>
Liability for incurred but not reported losses	<u>\$304,598,834</u>	<u>\$272,137,413</u>	<u>\$242,685,033</u>

Loss liabilities also include a provision for the estimated future payment of costs to settle claims. These ultimate loss adjustment expenses as of June 30, 1992, June 30, 1991, and June 30, 1990 are estimated at 4.0, 3.5, and 3.0 percent, respectively, of the projected ultimate loss liabilities. The loss adjustment expense paid from inception of the Fund are deducted from the projected ultimate loss adjustment expense provision to determine the liability for loss adjustment expense as follows:

	<u>June 30, 1992</u>	<u>June 30, 1991</u>	<u>June 30, 1990</u>
Projected ultimate loss adjustment expense liability	\$ 21,973,443	\$ 16,911,857	\$ 12,511,208
Less:			
Net loss adjustment expense paid from inception	<u>(7,031,493)</u>	<u>(5,457,743)</u>	<u>(4,055,405)</u>
Liability for loss adjustment expense	<u>\$ 14,941,950</u>	<u>\$ 11,454,114</u>	<u>\$ 8,455,803</u>

In establishing the Fund's loss liabilities and liabilities for loss adjustment expense, the Board of Governors relies upon the recommendations of a consulting actuary.

Inherent Uncertainty of Loss Liabilities

The uncertainties inherent in projecting the frequency and severity of claims because of the Fund's relatively short history, unlimited liability coverage, and extended reporting and settlement periods make it likely that the amounts ultimately paid will differ from the recorded estimated liabilities. These differences cannot be quantified.

The loss liabilities and liability for loss adjustment expenses are continually reviewed as adjustments to these liabilities become necessary. Such adjustments are reflected in current operations. During the fiscal year ended June 30, 1992, the estimated liabilities for years prior to FY 1991-92 and which would have been outstanding at June 30, 1992 were decreased by approximately \$5.2 million.

Discounted Loss Liabilities

Section Ins. 17.27(3), Wis. Adm. Code, requires the liability for reported losses, liability for incurred but not reported losses, and liability for loss adjustment expense be maintained on a present value basis with the difference from full value being reported as a contra account to the loss reserve liabilities. The loss reserve liabilities are discounted only to the extent that they are matched by cash and invested assets. If all loss liabilities are discounted, the discounted loss liability would be as follows:

	<u>June 30, 1992</u>	<u>June 30, 1991</u>	<u>June 30, 1990</u>
Estimated unpaid loss liabilities	\$348,046,364	\$323,639,364	\$281,867,478
Estimated unpaid loss adjustment expense	<u>14,941,950</u>	<u>11,454,114</u>	<u>8,455,803</u>
Total estimated loss liabilities	362,988,314	335,093,478	290,323,281
Less: amount representing interest	<u>(119,423,155)</u>	<u>(112,256,315)</u>	<u>(97,838,945)</u>
Discounted loss liabilities	<u>\$243,565,159</u>	<u>\$222,837,163</u>	<u>\$192,484,336</u>

The actuarially determined discount factor prior to FY 1989-90 was 6 percent. Statutory changes enacted on April 10, 1990, allow the Fund to invest in both short-term and long-term securities. In FY 1990-91, the Fund transferred approximately \$132 million from short-term investments to long-term investments. As a result, the discount factor was increased to 8 percent in FY 1989-90 and to 8.7 percent in FY 1990-91. To reflect the overall decline in investment earning rates, the discount factor was returned to 8 percent in FY 1991-92.

5. Future Medical Expense Liability

Section 655.015, Wis. Stats., requires accounts to be established for future medical expense awards in excess of \$25,000 that were entered into or rendered before June 14, 1986. Interest is allocated to the accounts quarterly based on the interest rate declared by the State of Wisconsin Investment Board.

6. Medical Mediation Panel

Section Ins. 17.27(3), Wis. Adm. Code, requires the fees collected for administration of the Medical Mediation Panel to be included in the Fund's financial reports, but that they should not be regarded as assets or liabilities or otherwise taken into consideration in determining assessment levels to pay claims. The Fund collected \$346,952 in fees in FY 1990-91. The Panel did not require fees for FYs 1991-92 and 1989-90.

7. Assessment Interest Income

Fund participants choosing a semi-annual or quarterly payment plan are assessed interest on the deferred assessment amounts. Section Ins. 17.28 (7), Wis. Adm. Code, prescribes the interest rate to be assessed on the deferred assessments as the average annualized rate earned by the fund for the first three quarters of the preceding fiscal year as determined by the State of Wisconsin Investment Board. Interest was assessed at the rate of 8.261 percent for FY 1989-90; 8.938 percent for FY 1990-91; and 8.128 percent for FY 1991-92.

8. Claim Annuities

The settlement of a claim may result in the purchase of an annuity. If the annuity company and the reassignment company default on annuity payments, the Fund remains responsible for the payments under the annuity arrangements. One of the Fund's annuity providers defaulted on \$23,921 in annuity payments in FYs 1991-92 and 1992-93, which the Fund subsequently paid. It is unclear when the annuity provider will be able to make the remaining annuity payments scheduled to be paid in FYs 1993-94 through 2015-16, which total an estimated \$3 million, and whether the Fund will be able to recover the annuity payments the Fund made on the behalf of the annuity provider.

9. Related Parties

The Fund's claims contract administrator is responsible for purchasing the claim annuities either directly from a provider of annuities or with the assistance of an annuity broker. The contract administrator used its internal brokerage department to purchase approximately 83 percent of the \$15.2 million in annuities for the Fund during FYs 1991-92, 1990-91, and 1989-90. The contract administrator does not directly charge the Fund for the services of its internal brokerage department, but receives commissions from the annuity providers ranging between 3 and 4 percent of the annuity price.

10. Contingent Liability

A medical clinic protested the amount of primary insurer contributions the Fund collected from it for a claim. A trial court affirmed that the clinic was entitled to the return of these funds. The Fund is currently negotiating with the clinic before proceeding with an appeal. Fund officials estimate a potential exposure of approximately \$1 million to the Fund.

11. Subsequent Events

Two large settlements were paid subsequent to June 30, 1992, including a settlement of \$7.6 million paid in November 1992 and a settlement of \$18 million paid in May 1993.

12. Audit Adjustments

The unaudited financial statements presented in the Commissioner of Insurance's annual reports to the Governor and Legislature have been adjusted for audit findings.

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REPORT ON THE INTERNAL CONTROL STRUCTURE IN ACCORDANCE WITH GOVERNMENT AUDITING STANDARDS

We have audited the balance sheet—regulatory basis as of June 30, 1992, 1991, and 1990, and the related statement of income and changes in fund deficit—regulatory basis and statement of cash flows—regulatory basis of the State of Wisconsin Patients Compensation Fund for the years then ended and have issued our report thereon dated June 4, 1993.

We conducted our audit in accordance with generally accepted auditing standards and *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the regulatory-based financial statements are free of material misstatement.

In planning and performing our audit of the regulatory-based financial statements of the Patients Compensation Fund for the years ended June 30, 1992, 1991, and 1990, we considered the Fund's internal control structure in order to determine our auditing procedures for the purpose of expressing our opinion on the regulatory-based financial statements, and not to provide assurance on the internal control structure.

The management of the Patients Compensation Fund is responsible for establishing and maintaining an internal control structure. In fulfilling this responsibility, estimates and judgments by management are required to assess the expected benefits and related costs of internal control structure policies and procedures. The objectives of an internal control structure are to provide management with reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition and that transactions are executed in accordance with management's authorization and recorded properly to permit the preparation of the regulatory-based financial statements in accordance with a format prescribed by the Board of Governors and in accordance with the accounting principles prescribed or permitted by the Commissioner of Insurance of the State of Wisconsin. Because of the inherent limitations in any internal control structure, errors or irregularities may nevertheless occur and not be detected. Also, projection of any evaluation of the structure to future periods is subject to the risk that procedures may become inadequate because of changes in conditions or that the effectiveness of the design and operation of policies and procedures may deteriorate.

For the purpose of this report, we have classified the significant internal control structure policies and procedures for administering the Patients Compensation Fund in the following categories: financial reports, claims, assessments, investments, and general and administrative expenses.

For all of the internal control structure categories listed above, we obtained an understanding of the design of relevant policies and procedures and whether they have been placed in operation, and we assessed control risk.

We noted certain matters involving the internal control structure and its operation that we consider to be reportable conditions under standards established by the American Institute of Certified Public Accountants. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control structure that, in our judgment, could adversely affect the entity's ability to record, process, summarize, and report financial data consistent with the assertions of management in the regulatory-based financial statements.

Our understanding of the internal control structure indicated that the Fund needs to continue steps to improve the accuracy and timeliness of its claim information and that the Fund needs to improve procedures over its claim annuities. These control deficiencies and concerns are discussed in the report section titled "Management of Claim Operations."

A material weakness is a reportable condition in which the design or operation of one or more of the specific internal control structure elements does not reduce to a relatively low level the risk that errors or irregularities in amounts that would be material in relation to the regulatory-based financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions.

Our consideration of the internal control structure would not necessarily disclose all matters in the internal control structure that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses as defined above. However, we believe none of the reportable conditions described above are material weaknesses.

We also noted other matters involving the internal control structure and its operation that we have reported to the management of the Fund in a separate memorandum dated January 6, 1993.

This report is intended for the information of management, the Board of Governors' Audit Committee, and the Wisconsin Legislature's Joint Audit Committee. However, this report is a matter of public record and its distribution is not limited.

LEGISLATIVE AUDIT BUREAU

June 4, 1993

by



Diann Allsen
Audit Director

COMPLIANCE REPORT BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH GOVERNMENT AUDITING STANDARDS

We have audited the balance sheet—regulatory basis as of June 30, 1992, 1991, and 1990, and the related statement of income and changes in fund deficit—regulatory basis and statement of cash flows—regulatory basis of the State of Wisconsin Patients Compensation Fund for the years then ended and have issued our report thereon dated June 4, 1993.

We conducted our audits in accordance with generally accepted auditing standards and *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the regulatory-based financial statements are free of material misstatement.

Compliance with laws, regulations, and contracts applicable to the Patients Compensation Fund is the responsibility of the management of the Patients Compensation Fund. As part of obtaining reasonable assurance about whether the regulatory-based financial statements are free of material misstatement, we performed tests of the Patients Compensation Fund's compliance with certain provisions of laws, regulations, and contracts. However, the objective of our audit of the regulatory-based financial statements was not to provide an opinion on overall compliance with such provisions. Accordingly, we do not express such an opinion.


The results of our tests indicate that with respect to the items tested, the Patients Compensation Fund complied, in all material respects, with the provisions referred to in the preceding paragraph. With respect to items not tested, nothing came to our attention that caused us to believe that the Patients Compensation Fund had not complied, in all material respects, with those provisions.

This report is intended for the information of management, the Board of Governors' Audit Committee, and the Wisconsin Legislature's Joint Audit Committee. However, this report is matter of public record and its distribution is not limited.

LEGISLATIVE AUDIT BUREAU

June 4, 1993

by


Diann Allsen
Audit Director

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FUND DEFICIT

Since at least FY 1980-81, the first year the Legislative Audit Bureau audited the Fund, it has reported an accounting deficit that reflects the difference between the estimated claim liabilities and the cash and investments currently available to pay them. Claim liabilities are based on estimates of what the Fund may need to pay for malpractice incidents that have already occurred, although they may not yet be reported. If the Fund were to cease operations and collect no additional provider assessments, which are its primary revenue source, the accounting deficit represents the approximate amount that would not be available to pay estimated claims for which the Fund has already provided coverage.

The Board of Governors relies on a consulting actuary to project the Fund's claim liabilities and to suggest the annual fees physicians and other health care providers should be assessed for coverage. Because a medical malpractice claim may be filed years after an incident and there is no limit on what the Fund may be required to pay, the actuary reviews and revises previous estimates annually, based on additional experience and information.

The Fund had an accounting deficit of \$79 million on June 30, 1992.

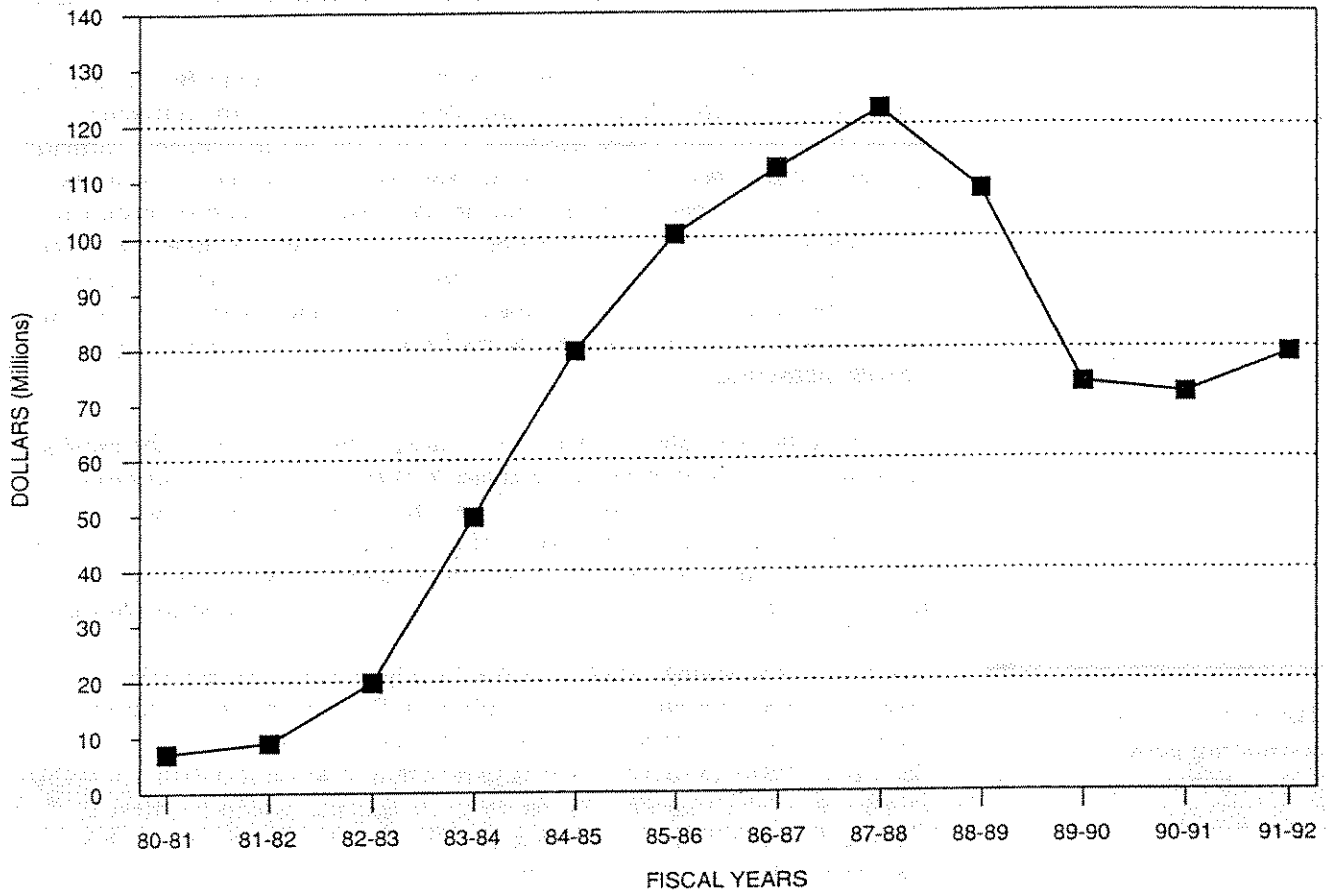
The Fund's accounting deficit, which is largely based on the actuarial estimates, grew to a high of \$122.7 million in FY 1987-88, as shown in Figure 1. This upward trend reversed in FY 1988-89, when the deficit decreased to \$108.3 million. The deficit continued to decline to \$71.7 million at the end of FY 1990-91, but then began another increase in FY 1991-92. The deficit was \$79 million on June 30, 1992, and is expected to reach at least \$80 million by the end of 1993.

Investment earnings help reduce the amount of provider assessments needed to pay claims.

Some argue that the Fund's financial picture is not as bleak as the accounting deficit figure represents, since the Fund has always had sufficient cash to pay claims and other operating expenses and its cash and investments have grown to over \$197 million as of June 30, 1992. However, because investment earnings help to reduce the provider assessments that fund claim payments, maintaining a large investment balance is important. This was recognized in 1989 Act 187, which allowed the Fund to make long-term investments. The significant decrease in the deficit in FY 1989-90 largely resulted from a change in the actuary's investment assumption for the expected higher returns from long-term investments.

Figure 1

Fund Deficit



In the past, the Fund has generally received more in premium income than it paid out in claims and, as a result, the investment balance grew significantly. As shown in Figure 2, investment income, which reached \$18.3 million in FY 1991-92, represents a larger portion of total income in recent years. However, the Fund's continued ability to increase or even maintain investment balances in the long term is uncertain, as annual amounts paid out in claims increase.

Figure 2

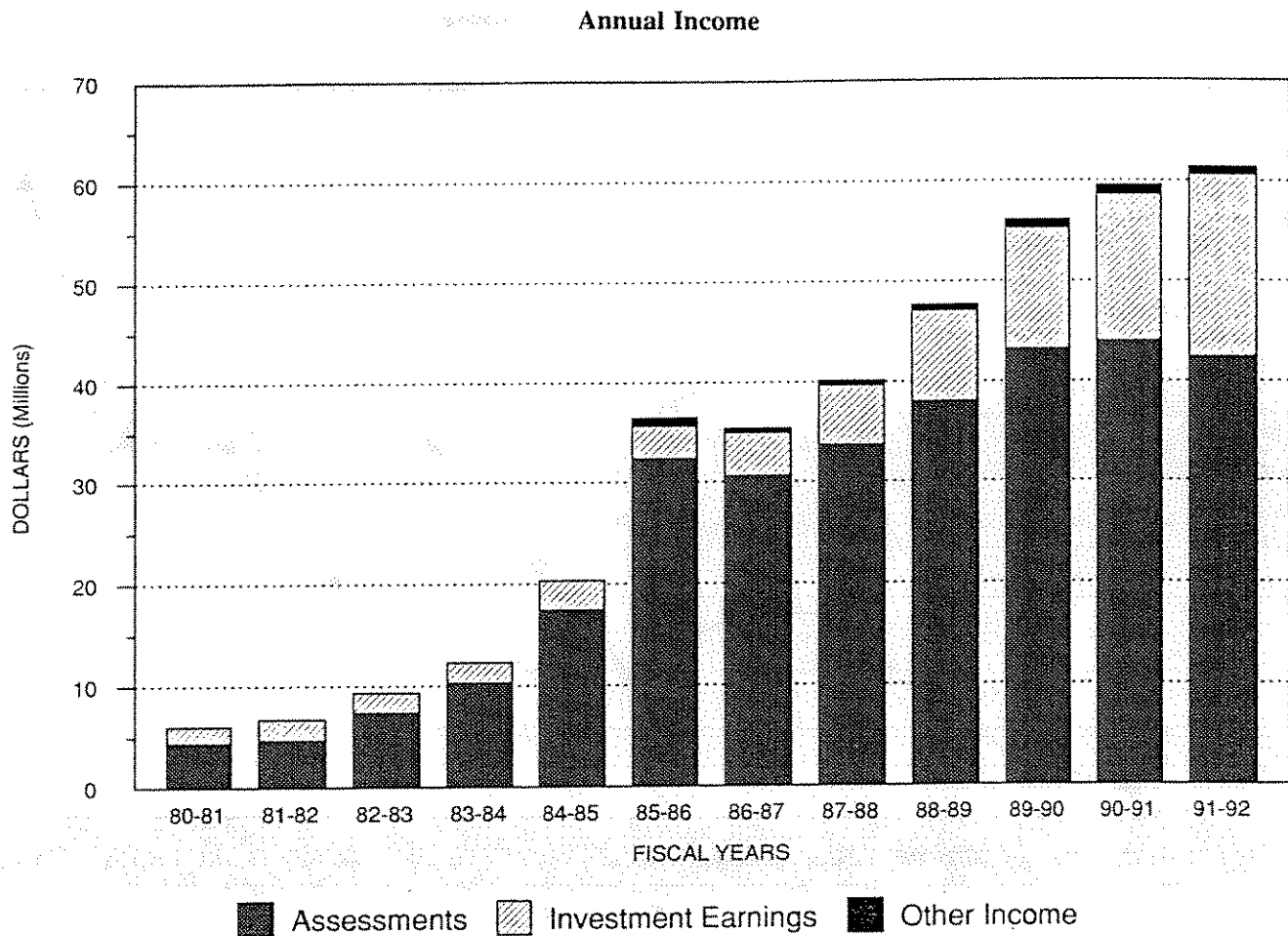
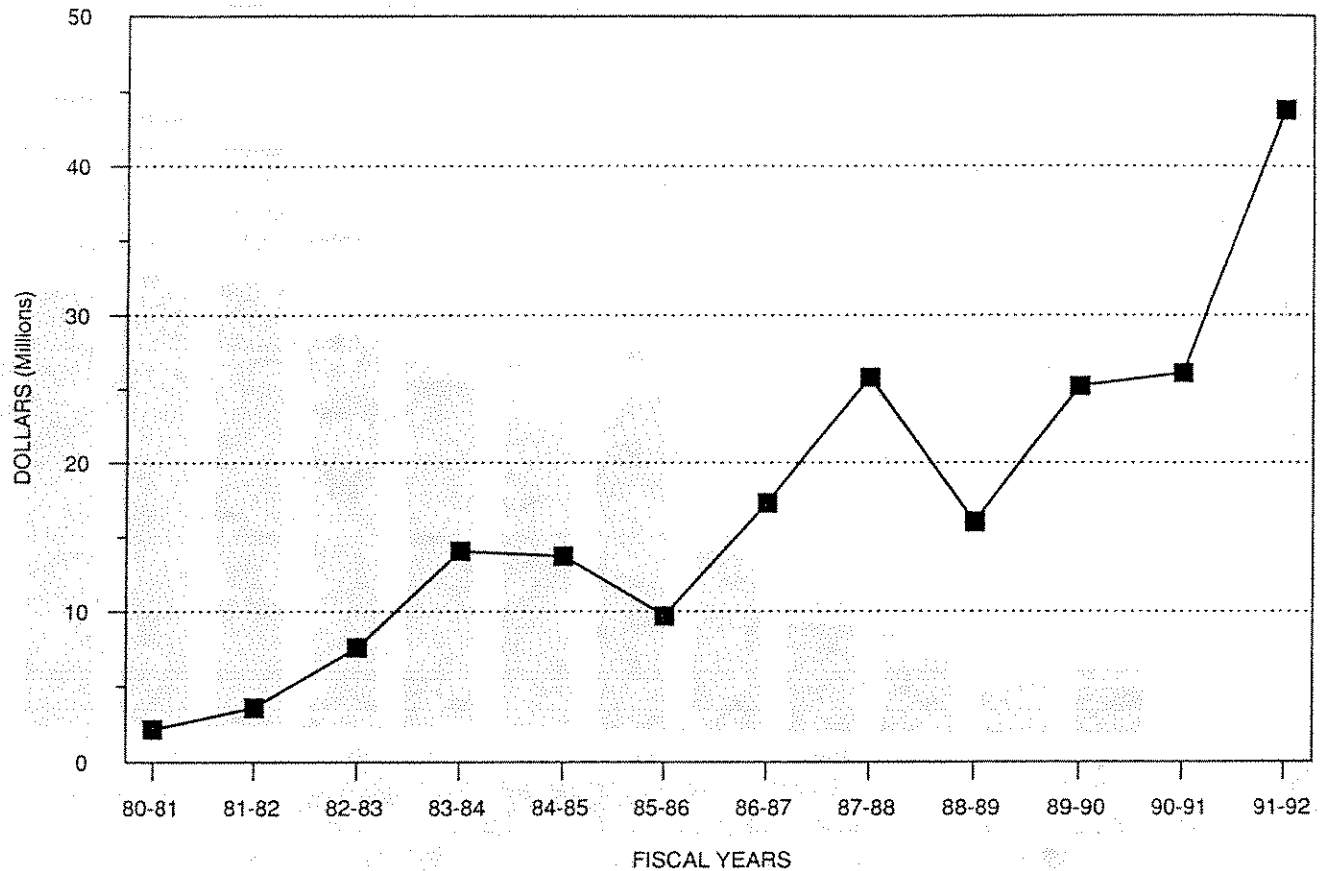


Figure 3 shows that although the amount paid out in claims and expenses to settle claims fluctuates on an annual basis, the general trend has been upward. The Fund paid almost \$44 million in claims and related expenses in FY 1991-92, an increase of 68 percent from the previous year. Fund staff project the Fund will pay almost \$49 million in claims and related expenses during FY 1992-93. Previously, the largest amount of claims and related expenses paid in one year totaled \$26 million. Further, the actuary projects the Fund will need to pay an average of \$38 million in claims and related expenses over the next five years for incidents that have already occurred. In addition, the Fund will need to pay claims for incidents occurring during the next five years, which are not yet included in the actuary's projection.

Figure 3

Paid Claims and Claim Expenses



The Fund paid its largest individual claim, \$18 million, in May 1993.

We cannot predict when the Fund will have cash flow problems because future claim settlements, which are based on negotiations or litigation that may result in different settlement amounts for similar claims, cannot easily be projected. Further, the effect of recent large settlements on future claims is unknown: the Fund paid a claim of almost \$8.5 million in July 1991, a claim of \$7.6 million in November 1992, and a claim of \$18 million in May 1993. Prior to these three cases, the largest claim payment from the Fund was \$4.8 million. Nevertheless, it appears likely that claim costs will continue to increase.

The Fund could experience cash flow problems within 15 to 20 years if current trends continue.

If the general trend in claims and related expenses continues to move upward and the health care providers' annual fees remain at the FY 1993-94 level, we project the Fund's cash and investment balance could begin declining within the next 10 years, resulting in a cash flow problem within the next 15 to 20 years. Although potential cash flow problems appear to be a long-term concern, they will be difficult to address unless additional steps are taken now to control the accounting deficit through increased assessments or decreases in future claim expenses.

As shown in Table 2, the Board of Governors increased assessments in the past in an attempt to stabilize the deficit. However, the Board of Governors' future ability to increase assessments in order to eliminate, or even stabilize, the accounting deficit may be limited by concerns about health care providers' ability to afford increases in annual assessments, which ranged between \$716 and \$16,044 during FY 1992-93, depending on health care providers' specialties. In response to concerns about the magnitude of earlier rate increases, the Legislature established statutory limits on the level of the Fund's annual assessments as part of 1985 Act 340.

The deficit is likely to increase, even with a 10 percent increase in fees during FY 1993-94.

Most recently, the Assembly Committee on Insurance, Securities, and Corporate Policy did not approve the Board's proposed overall 16.8 percent increase in assessments to be effective July 1, 1993, which was the actuarially projected fee level necessary to limit further growth in the deficit during FY 1993-94. Instead, the Assembly committee recommended a 10 percent increase in fees. The Board will implement the recommended 10 percent increase to ensure timely collection of FY 1993-94 fees, but in a resolution adopted on July 2, 1993, the Board expressed its objection to a fee increase less than 16.8 percent and projected the deficit will increase by \$4.5 million with the 10 percent increase.

Table 2

Annual Assessment Changes

<u>Effective Date</u>	<u>Percentage Change</u>
July 1, 1983	42.2%
July 1, 1984	77.5
July 1, 1985	90.0
July 1, 1986	(4.2)
July 1, 1987	8.0
July 1, 1988	10.6
July 1, 1989	11.0
July 1, 1990	0.0
July 1, 1991	(4.7)
July 1, 1992	4.0
July 1, 1993	10.0

The Legislature considered reestablishing a limit on noneconomic damages.

Some have argued that further reduction of the Fund's accounting deficit depends on decreasing future claim expenses, either by increasing the threshold at which the Fund becomes liable or by establishing maximum claim awards the Fund will pay. During the 1993-94 legislative session, several bills were introduced to reinstate statutory limits on noneconomic damages a medical malpractice settlement may award for pain and suffering, embarrassment, mental distress, and loss of society and companionship. The statutes required a limit on noneconomic damage awards of \$1 million beginning in June 1986, to be adjusted annually to reflect changes in the consumer price index until sunset of the provision in December 31, 1990. No statutory noneconomic damages limit has been in place since then.

While limitations on noneconomic damages could help temper growth in the Fund's future claims costs, such limitations alone are not likely to control the accounting deficit, since economic damages for future medical and care costs and loss of earnings capacity represent the largest portion of medical malpractice awards. As one means to limit the amount paid for economic damages, fund officials are considering the feasibility of reestablishing accounts that would pay future medical expenses. Until June 1986, statutes required award amounts in excess of \$25,000 for future medical expenses to be paid into the Patients Compensation Fund, which would pay the expenses as they were incurred until either the award amount was exhausted or the patient died. Such future medical expense accounts could limit the amount of claim costs the Fund pays for cases in which the claimant dies before full settlement is paid and for cases in which the claim award exceeds necessary medical expenses.

The Fund is coordinating risk management activities to help prevent claims.

In addition to steps that limit the amount the Fund pays on claims, efforts to reduce occurrences of medical malpractice claims also will be important in controlling claim costs. The Fund took initial steps in this area by establishing a Risk Management Steering Committee and contracting with a health care risk management firm, beginning in 1991, to develop and coordinate statewide strategies to help providers modify practices or behaviors that may be associated with lawsuits, so that claims are prevented or are easier to defend.

Similarly, Senate Bill 44 includes a provision requiring the Department of Health and Social Services to study the progress other states, the federal government, and societies of medical specialists have made in establishing health care practice protocols that, if adhered to, would create a legal presumption against liability for malpractice. Under the proposed language, the Department is to report to the Legislature by July 1, 1994, on its findings and recommendations regarding actions Wisconsin may want to consider in establishing similar protocols.

The effect of current or proposed steps in addressing the Fund's accounting deficit is difficult to project. Further, national health care and medical malpractice reform efforts may affect the Patients Compensation Fund and Wisconsin's statutory medical malpractice provisions, although it is too early to determine the exact effects. Under proposals currently being considered as part of the national health-care reform plan, patients who believe they are victims of malpractice would sue their insurance plans rather than the

individual doctors. However, even if the national health care and medical malpractice reform plans reduced or eliminated the need for the Fund, the Fund's current liabilities would remain and need to be paid.

Therefore, it is important that the Board and the Legislature continue to monitor and assess the need for additional measures to address the deficit. The Board of Governors is establishing a study group, which will consist of members of the Board and staff of the Fund, to evaluate alternatives for addressing the fund deficit. The study group is expected to report to the full Board by March 1994, at which time the Board will consider what steps to pursue. We recommend the Board of Governors report the results of its study committee and the Board's planned steps to address the deficit to the Joint Legislative Audit Committee by June 30, 1994.

MANAGEMENT OF CLAIM OPERATIONS

Effective claim operations are necessary to ensure claims are properly processed, accurate claim information is maintained, and the Fund's liability for claims is minimized. The Fund contracts with a private insurance company to administer the Fund's claim operations by investigating and monitoring individual malpractice claims, establishing the reserve balances for expected claim payments, and maintaining the claim systems. Fund staff retain responsibility for monitoring the claim operations.

During our past audits, we identified significant weaknesses in the Fund's claim operations and errors in the accuracy of claim information. Fund staff have shown a commitment to improve the Fund's operations and have taken several steps in recent years to address the deficiencies. However, we note that the Fund needs to:

- continue steps to improve the accuracy and timeliness of claim information; and
- improve its monitoring and reporting of annuity settlements.

Accuracy and Timeliness of Claim Information

The Fund is taking steps to improve the accuracy and timeliness of its claim information.

Accuracy and timeliness of claim information are important because the Fund's consulting actuary uses the information to project the Fund's claim expenses, which are included in financial reports and are considered by the actuary in proposing assessment levels. In the past, significant errors and lack of timeliness in claim information resulted primarily from inadequate communication and coordination between fund staff and the claims contractor, especially with respect to separate claim systems maintained by the claims contractor and the Fund. In response to these concerns, the Fund:

- hired a subcontractor to design a single claim system to be maintained by the claims contractor, which was implemented in March 1992;
- reconciled financial information from the two previous systems before it was entered on the new system;
- contracted with a public accounting firm to audit the contractor's claim operations; and
- established additional claim policies and procedures for the contractor, such as a limit of 60 days during which a file can remain open after receipt of final release papers.

These improvements in claim operations have increased significantly the accuracy and timeliness of claim information. However, during our testing of 110 claims, we still found 6 cases in which dates on the computer system did not agree with paper files, and 15 cases in which changes to the status of claims were not reported in a timely manner by the claims contractor. In response to our concerns, fund staff noted additional steps they will take to continue improving the accuracy and timeliness of claim information. These include further reconciliation of nonfinancial information from claim files to the computer, and a claims contract that includes penalties for any noncompliance with requirements by the claims contractor.

Annuity Settlements

Periodically, claim settlements require a series of payments over the claimant's lifetime, rather than one lump-sum payment. The Fund's claims contractor purchases annuities on the Fund's behalf, either directly from an annuity company or with the services of an annuity broker. The Fund paid a total of \$15.2 million for annuities for the three-year period ended June 30, 1992, which represents approximately 17 percent of the claims paid during that period. The projected payout for these annuities is over \$131 million.

Section 655.27 (2), Wis. Stats., exempts the Fund from most state procurement rules and processes when contracting for services necessary for the Fund's operations and requires the Fund to promulgate rules to govern the contracting process. The Board of Governors has interpreted the statutory exemption to include brokerage services for annuities. Although the Fund may be exempt from state purchasing requirements, it is still important that it take reasonable measures to find the best terms and prices for the annuities, such as obtaining multiple quotations from annuity providers.

Further, it is important that the Fund ensure the financial soundness of the company selling an annuity because the Fund remains ultimately responsible for payment should the annuity company default. Such steps need to include:

- establishing criteria for the selection of annuity companies, such as their financial ratings;
- contracting with multiple annuity companies to minimize losses in case an annuity provider becomes insolvent; and
- maintaining adequate records of the annuity settlements.

An annuity provider defaulted on \$23,921 of the Fund's claim settlement annuities.

A default on \$23,921 in annuity payments by one of the Fund's annuity providers during FYs 1991-92 and 1992-93 exemplifies the importance of such steps. It is unclear when the annuity provider will be able to make remaining annuity payments in the future and whether the Fund will be able to recover the annuity payments the Fund made on the behalf of the annuity provider.

The Fund established guidelines and criteria for the selection of annuity companies in 1987, including requirements for obtaining at least two quotations and criteria for eligible annuity companies. In response to the

defaulted payments, the Fund updated its guidelines in 1992 to require higher ratings from insurance and investment rating organizations and thereby increase assurances of the financial soundness of future annuities. Despite the improvements, we have concerns with:

- potential conflicts of interest when annuities are purchased through the claims contractor's internal brokerage department; and
- the lack of records and procedures to monitor and report on the Fund's potential liability exposure for the annuity settlements.

Potential Conflicts of Interest

The claims contractor used its internal brokerage department to purchase \$12.6 million, or 83 percent, of the total \$15.2 million in annuities purchased for the Fund during FYs 1991-92, 1990-91, and 1989-90. The last seven annuities purchased through the contractor's internal brokerage department, which totaled \$7.9 million, were purchased from the same annuity company.

Annuity purchases may raise conflict-of-interest questions.

We believe the predominate use of the claims contractor's internal brokerage department and the recent concentration in one annuity company raise potential conflict-of-interest concerns. The claims contractor's documentation indicates that its internal brokerage department obtained quotations from three annuity providers for each annuity purchase and that the selected annuity companies offered the lowest price. However, the perception may be that commissions the internal brokerage department receives from the annuity provider provide an incentive for the contractor to act in its own, rather than the Fund's, best interest. Although the contractor was unable to provide records of the specific commissions received for the annuities, contractor staff indicate that commissions generally range between 3 and 4 percent of the annuity purchase price; that would have amounted to between \$378,000 and \$503,000 in commissions for the \$12.6 million of annuities purchased through the contractor's internal brokerage department.

Staff of the fund recognized these concerns and in a contract signed in May 1993, included restrictions that the claims contractor cannot receive more than 50 percent of total annuity brokerage fees for the three-year contract period. However, we believe such restrictions do not eliminate potential conflict-of-interest concerns. Therefore, we recommend the Board of Governors prohibit the claims contractor from receiving commissions from annuity providers for annuities purchased for the Patients Compensation Fund and amend its annuity guidelines to include specific criteria for contracting with multiple annuity companies to further reduce the risk of defaults.

Monitoring and Reporting on Annuities

To minimize the risk of defaulted payments on annuities it has already purchased, the Fund also needs to better monitor and report on their status by maintaining more comprehensive records on annuity settlements and periodically reviewing the financial strength and ratings of the annuity companies. Further, accounting standards require that the Fund consider and disclose in its financial reports any potential exposure for annuities if there is a reasonable possibility the Fund may need to pay them because of default.

Although the claims contractor maintains annual annuity logs that include some basic annuity information, such as the amount of the annuity purchased, the name of the annuity company, and the total projected payout, neither the contractor nor fund staff maintains a comprehensive list of outstanding amounts to be paid by the annuity companies, or regularly analyzes the annuities or the Fund's potential exposure for them. To better monitor its risk for defaulted annuity payments and meet accounting requirements, we recommend the Patients Compensation Fund maintain a comprehensive list of annuity settlements, periodically monitor the status of the annuity companies, and disclose the Fund's exposure for outstanding annuities in its financial reports.

APPENDIX



State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Tommy G. Thompson
Governor

Josephine W. Musser
Commissioner

July 16, 1993

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DALE CATTANACH STATE AUDITOR
LEGISLATIVE AUDIT BUREAU
131 W WILSON ST
MADISON WI 53703

Re: Audit Report on Patients Compensation Fund

Dear Mr. Cattanach:

Thank you for giving us the opportunity to comment on the draft audit report of the Patients Compensation Fund (Fund) for fiscal years 1991-92, 1990-91, and 1989-90. I appreciate your audit comments noting improvement and a commitment by Fund staff to improve the claims operation. We will continue to monitor the claims system for accuracy and timely reporting of claim information. The audit comments concerning prohibiting the claims contractor from receiving commissions from annuity business purchased on behalf of the Fund and spreading annuity business across more annuity insurers to avoid concentration in one carrier will be directed to the Fund's Board of Governors (Board) for its action.

I also share your concerns over the magnitude and growth in the Fund's deficit. It would appear that some legislative action will be required to assist the Fund's Board in its attempts to retire the Fund deficit. Your report accurately reflects the Fund Board's attempt to promulgate a fund fee rule for fiscal year 1993-94 at the break-even funding level to stabilize the deficit. As your report also notes, through the legislative review process, the level of increase was reduced to a 10% increase which is projected to increase the Fund's June 30, 1993, deficit of \$80 million by \$4.5 million over the next 12 months. I also appreciate the inclusion in your report on the steps that the Fund's Board is taking to control claims costs, including implementation of a statewide risk management program and evaluating the fiscal effect of various tort reform proposals.

In conclusion, we appreciate the thoroughness of your audit and hope that it provides the impetus for future discussions concerning efforts to improve Fund operations and retire the deficit.

Best regards,

A handwritten signature in cursive script, reading "Josephine W. Musser".
Josephine W. Musser
Commissioner of Insurance

JWM:DCB:sf
2769Q

